DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
( )	050667	A. BUILDING _____ B. WING _____	02/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
N M HOLDERMAN MEMORIAL HOSPITAL	260 CALIFORNIA DR YOUNTVILLE, CA 94599

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A 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a RECERTIFICATION survey. The sample size was two open and 18 closed clinical records. Representing the Department: Candice Bergseth, Health Facilities Evaluator Nurse (HFEN) Carol Devita, HFEN Adrian Long, HFEN Gerri Kaplan, Health Record Information Specialist Maelin Yee, Occupational Therapist Thomas Garrett, Physician John Christensen, Pharmacist	A 000	Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the provider to the truth of the facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed because it is required by the provisions of Health and Safety Code Section 1250 and 42 C.F.R. 405.1907 ( ) initials This Plan of Correction constitutes our written credible allegation of compliance for the deficiencies noted.	
A 396	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. This STANDARD is not met as evidenced by: Based on interview and record review, the hospital failed to ensure that nursing care plans were developed for 3 of 20 sampled patients. (Patients 5, 13, and 14) Findings: 1. Patient 5 was admitted to the acute care hospital following an accidental overdose of	A 396	**A 396 Plan of Correction**: The hospital will ensure that the nursing staff develops and keeps current a nursing care plan for each patient. **Amended Findings 1 through 3:** Acute patients will have nursing care plans developed upon admission that meet the individual needs of each patient. 1South staff will receive an in-service that pertains to "Developing a Comprehensive Care Plan." Residents 5, 13, and 14 had already been discharged at the time of this survey, so the care plans could not be corrected.	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Margaret Anderson — SCC — 3/17/08

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ollowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

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A 396	Continued From page 1 Ativan (antianxiety medication). The admission summary history and physical, dated 7/13/07, revealed that the "Plan" for Patient 5 included admission to 1 South for observation, close monitoring, vital signs, to ensure respirations are not depressed, IV hydration, and decrease in Methadone. The medical record lacked evidence of a care plan that addressed the steps in monitoring and education of a patient who had overdosed. 2. Patient 13 was admitted to the acute care hospital with psychiatric diagnoses, multiple psychiatric medications, and an antidepressant. Medications included Depakote ER, mood stabilizer, Zyprexa and Seroquel for psychosis, and Wellbutrin for depression. The medical record lacked evidence of a care plan that addressed Patient 13's psychiatric history, antipsychotic medications, and potential side effects. During an interview with supervisory staff on 1/29/08 at 3:30 pm, staff acknowledged that care plans had not been developed for Patients 5 and 13. 3. Patient 14 was admitted to the acute care hospital with a history of paroxysmal atrial fibrillation (irregular heart beat), sick sinus syndrome (group of abnormal heart rhythms), and pacemaker placement (2004). Her medications included Warfarin (anticoagulant) 3 mg. daily. The medical record lacked evidence of a nursing care plan that addressed Patient 14' s cardiac condition and anticoagulant therapy precautions. During an interview with supervisory staff on 1/30/08 at 11:00 am, staff acknowledged that a	A 396	**Amended Correction continued from page 1:** **Responsible**: Supervising Registered Nurse II or designee. **Monitor:** The Supervising Registered Nurse or designee will conduct concurrent chart reviews to determine the timeliness and appropriateness of the nursing care plan. Negative findings will be corrected promptly and reported through the Clinical Services Quality Improvement Committee. The indicators for this monitor will continue until we have met or exceeded the threshold for one quarter or three consecutive months.	03/26/08

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A 396	Continued From page 2 care plan had not been developed for Patient 14.	A 396	**Continued from page 2:**	
A 405	482.23(c)(1) ADMINISTRATION OF DRUGS All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the hospital failed to ensure that oxygen was administered in accordance with the physician's order for one of 20 sampled patients and failed to implement Medication Storage and Labels policies for 2 of 5 medication storage areas inspected. (1) Findings: 1. The policy and procedure for Oxygen Therapy includes the following: The licensed nurse and /or respiratory therapist is responsible for initiating and maintaining oxygen therapy according to the physician order. Patient 1 had a physician's order, dated 1/23/08, for oxygen therapy at 2 liters nasal cannula. During an observation on 1/29/08 at 10:30 am, the oxygen flow meter was set above the physician's order at 3.5 liters.	A 405	**A 405 Plan of Correction:** Drugs and biologicals will be administered in accordance with regulations and approved medical staff policies and procedures. **Finding 1.** Patient's 1's oxygen flow was immediately adjusted to correlate with physician orders. 1 South staff will receive an in-service regarding the standard that all physician orders will be followed as written. Shift Lead RN will be responsible to ensure that oxygen is being administered as ordered. **Responsible:** Supervising Registered Nurse II **Monitor**: The RN will monitor oxygen orders to ensure correct administration. Negative findings will be corrected immediately and employee counseling conducted as necessary. **Finding 2.1**: The PPD vial was immediately dated per VH Policy. Multi-dose medication vials will be dated when opened and indicate a discontinuation date. 1 South staff will receive an in-service pertaining to Pharmacy Policy Chapter 4, page 4, pertaining to labeling open multi-dose vials. **Responsible:** Supervising Registered Nurse and Supervising Registered Nurse II	03/26/08

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A 405	Continued From page 3 Upon interview with unit licensed staff on 1/29/08 at 10:30 am, staff concurred that the oxygen flow rate was not set to the physician's specified order of 2 liters. 2. Facility policy for "Medication Storage and Labels" includes the following: The nurse will label multidose vials with the date the vial is opened. Multidose vials are discarded 30 days after opened or sooner as recommended by manufacturer or Pharmacy Services. 1. During inspection of the medication refrigerator in the Ambulatory Care Center on 1/29/08 at 10:15 am, 1 vial of PPD (used for Tuberculosis testing) was discovered to be open and available for use. The vial did not have a date confirming when it was opened for use. During an interview with licensed staff on 1/29/08 at 10:15 am, staff stated that she had just opened the vial ten minutes ago, but had not dated the vial. 2. During inspection of the 1 South medication refrigerator on 1/29/08 at 11:00 am, three multi-dose vials were open, undated and available for use; Lantus Insulin, Humalog Insulin, and one vial of PPD. During an interview with the pharmacist on 1/29/08 at 11:00 am, he stated that the vials should have been dated when opened. There was no indication how long the vials were in use.	A 405	**Continued from page 3:** **Finding 2.2:** The three multi-dose vials were immediately discarded and replaced with new vials that were dated when opened according to VH Policy. **Responsible:** Supervising Registered Nurse **Monitor:** Monthly environmental rounds are conducted by the Supervising Registered Nurse or designee. Negative findings will be corrected promptly and reported through the Clinical Services Quality Improvement Committee	03/26/08
A 450	482.24(c)(1) MEDICAL RECORD SERVICES All patient medical record entries must be legible, complete, dated, timed, and authenticated in	A 450	**A 450 Plan or Correction:** Medical record entries will be legible, complete, dated, timed and authenticated.	

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A 450	Continued From page 4 written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. This STANDARD is not met as evidenced by: Based on medical record review, the facility failed to ensure that all entries are complete and authenticated by the person responsible for providing or evaluating the service provided, in four closed patient charts containing Fluid Balance forms (3, 6, 10, and 16) and two of 18 closed patient charts containing Personal Effects Inventory sheets (9 and 19) Findings: 1. On 1/28/08, closed medical record review revealed that four of four charts contained Fluid Balance forms. All of these forms lacked a date of completion and the identification/signature of the author. 2. On 1/28/08, closed medical record review revealed that the Personal Effects Inventory sheets (VH-H-58a) lacked an area for for signature of patient and staff upon discharge.	A 450	**Continued from page 4:** **Finding 1**: The Fluid Balance Form will be re-designed to reflect signature of the writer and date completed. In-service to the revised form, once approved, will be provided. **Responsible**: Supervising Registered Nurse II or designee **Monitor**: Concurrent chart review will be conducted to ensure all entries on the forms are complete and authenticated. Negative findings will be corrected promptly and reported through the Clinical Services Quality Improvement Committee. **Finding 2**: The Personal Effects Inventory form VHH 58a will be revised to document personal effects inventoried upon admission and discharge. In-service to the revised form will be provided. **Responsible**: Supervising Registered Nurse II or designee **Monitor**: Concurrent chart review will be conducted to ensure all entries on the personal effects form are complete and authenticated. Negative findings will be reported through the Clinical Services Quality Improvement Committee.	03/26/08 03/26/08
A 467	482.24(c)(2)(vi) CONTENT OF RECORD - OTHER INFORMATION [All records must document the following, as appropriate:] All practitioner's orders, nursing notes, reports of treatment, medication records, radiology and laboratory reports, and vital signs and other information necessary to monitor the patient's condition.	A 467	**A 467 Plan of Correction**: Forms contained within the medical record will be complete.	

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A 467	Continued From page 5 This STANDARD is not met as evidenced by: Based on medical record review, the facility failed to ensure that all forms contained within the charts documented patients' allergies for 7 of 18 closed records and failed to ensure one of 18 closed records had a physician's order transcribed correctly. These failures had the potential to result in a lack of vital information necessary to monitor the patient's condition. (Patients 3, 5, 6, 7, 8, 10, 13, and 16) Findings: 1. On 1/28/08, closed record review revealed that Patients 3, 6, 10 and 16 charts contained Physician Order forms, Acute Patient Medical Record forms, Treatment sheets, and Diabetic Medication forms. All of these forms lacked identification of the patients' allergies or no known allergies in the space provided on these documents. Patient 3 has multiple allergies which include: Sulfa, Codeine, and anti-inflammatory drugs. 2. On 1/29/08 at 9:30 am, clinical record review indicated that Patient 7 is allergic to Penicillin, Ketoconazole, Vicodin, Benadryl, Atacard, and Zocor. The Physician's Orders and Acute Patient Medication Record lacked evidence of documentation of the patient's allergies. 3. On 1/29/08 at 10:00 am, clinical record review indicated that Patient 8 is allergic to Compazine, Benzocaine, Iodine, Sulfa, Contrast Dye, Rocephin and Progesterone Cream. The	A 467	**Continued from page 5:** **Findings 1 through 4:** Allergy information will be documented on the forms as indicated. Nursing service will be in-serviced on documentation of allergies. **Responsible:** Supervising Registered Nurse II and Supervising Registered Nurse **Monitor:** Acute care records will be concurrently reviewed to ensure allergies are documented. Negative findings will be corrected immediately. A quality improvement monitor will be developed and reported through the Clinical Services Quality Improvement Committee. Indicators for this monitor will continue until we have reached or exceeded threshold for one quarter or three consecutive months. **Finding 5**: "Sliding Scale Insulin Coverage" orders will be transcribed correctly. Training will be provided for acute care staff regarding the "Transcription of Physician Orders". Staff involved in transcribing order on Patient #13's record was counseled regarding the correct order transcription. Staff involved in the 24-hour routine order verification process was counseled regarding the importance of reviewing "Sliding Scale Insulin Coverage" orders carefully to make sure they are correct. **Responsible:** Supervising Registered Nurse and Supervising Registered Nurse II	03/26/08

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A 467	Continued From page 6 Physician's Orders, Diabetic Med Sheet,Acute Patient Medication Record, and PRN Medication Record lacked evidence of documentation of the patient's allergies. 4. Record review on 1/29/08 at 10:15 am, revealed that Patient 5 is allergic to Iodine dye and Lupron. The acute patient medication record, prn (as needed) sheet, and the medication record for parenteral therapy lacked evidence of documentation of the patient's allergies. 5. Record review on 1/28/08 at 2:30 pm revealed Patient 13's diagnoses included diabetes with the following physician's order, dated 11/09/07, for sliding scale Insulin coverage: For BS (blood sugar) 100-150- 3 units Lispro sc (subcutaneously). 151-200 - 5 units 201-250 - 6 units 251-300 - 7 units 301-350 - 10 units 351-400 -12 units Greater than 401 - 15 units. Review of the Diabetic medication sheet revealed the following entry: 100-150- 3 units 150-200 - 5 units 200-250 - 6 units 250-300 - 7 units 300-350-10 units 350-400-12 units Greater than 401- 15 units. Record review revealed that the order transcribed onto the diabetic medication record did not reflect the physician's order.	A 467	**Continued from page 6:** **Monitor:** Acute care records will be concurrently reviewed to ensure correct transcription of physician orders. Negative findings will be corrected immediately. A quality improvement monitor will be developed and reported through the Clinical Services Quality Improvement Committee. Indicators for this monitor will continue until we have reached or exceeded threshold for one quarter or three consecutive months.	03/26/08

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A 467	Continued From page 7 During interview with supervisory staff on 1/29/08 at 3:30 pm, staff acknowledged that the order had been transcribed incorrectly.	A 467	**Continued from page 7:**	
A 491	482.25(a) PHARMACY ADMINISTRATION The pharmacy or drug storage area must be administered in accordance with accepted professional principles. This STANDARD is not met as evidenced by: Based on observation, staff interview, clinical record and document review, the hospital failed to follow their policy for personal medications brought into the hospital by patients. The hospital failure to do so created the potential for patients receiving unidentified medications and possible drug errors for 2 of 20 sampled patients (Patient 2 and Patient 7). The hospital also failed to ensure that a drug storage area was maintained under sanitary conditions. Findings: 1. Review of Patient 2's clinical record on 1/28/08 at 3:00 pm reflected a Physician's Order, dated 1/22/08 at 7:40 pm, that indicated Patient 2 "May take own meds (medications) from section tonight." Review of the Medication Transfer List (a list of Patient 2's personal medications brought from home upon admission), indicated that the patient had five medications which included Celebrex (an anti-inflammatory), Prilosec (an acid	A 491	**A 491 Plan of Correction**: The Pharmacy drug storage area will be administered in accordance with accepted professional principles. **Findings 1 and 2**: Pharmacy's Policy/Procedure Manual, Chapter IV, "Personal Medication Policy and Procedure," was revised and approved by the Pharmacy/Therapeutics Infection Control Committee (PTIC) on February 5, 2008. The revised policy addresses the requirement for the attending physician or pharmacist verification and documentation of the medications to be used by the patient. Physicians and Pharmacists will be in-serviced to the revised policy. **Responsible**: Chief of Pharmacy Services **Monitor**: A quality improvement monitor, checking the use and documentation of personal medications, will be presented to the PTIC Committee at the next meeting scheduled April 8, 2008. Collected data will be reviewed and evaluated through the PTIC Committee. The indicators for this monitor will continue until we have met or exceeded threshold for one quarter or three consecutive months. **Finding 3:** Remnants of janitorial supplies will be removed from Room ACC-63.	04/08/08

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A 491	Continued From page 8 reducer)Doxazosin (for esophageal reflux), Ferrous Sulfate (iron tablet), and Warfarin Sodium (a blood thinner). 2. Review of Patient 7's clinical record on 1/29/08 at 9:30 am reflected a Physician's Order dated 1/23/07 at 4:15 am, that indicated Patient 7 "May take meds from section." There was no documented Medication Transfer Sheet that listed the medications Patient 7 brought into the hospital from home. On 1/29/08 at 11:20 am, review of the hospital policy titled "Personal Medications Policy and Procedure" (no date), indicated; "POLICY: Medications brought by or with the patient to the facility shall not be used unless the drug is a specialty item not readily available to the (hospital) pharmacy. PROCEDURE: 1. If personal medication is to be used by the patient ...1.3 The contents must be examined and judged safe for use by the attending physician or pharmacist." There is no documented evidence that indicated a physician or pharmacist examined the medications for safe use by Patient 2 or Patient 7. During interview on 1/29/08 at 11:30 am, administrative pharmacy staff stated that there is no pharmacist in the hospital after 6:00 pm or before 8:00 am Monday through Saturday and the Pharmacy is closed on Sunday. Administrative pharmacy staff stated the attending physician examines, approves, and documents that the patient's medications brought in from home have been checked and are safe to be administered until a pharmacist is on duty. Administrative pharmacy staff acknowledged that the policy did	A 491	**Continued from page 8:** Room ACC-63 will be renamed from "Janitorial" to "Utility". (Work order #26930 dated 3/3/08). A temporary sign has been installed. Room ACC-63 will be maintained in a sanitary condition and added to the monthly Pharmacy Inspection Roster. Food items will not be kept in the freezer compartment of the refrigerator/freezer located in Room ACC-63. Staff will be in-serviced to include appropriate storage conditions as part of the monthly inspections. **Responsible:** Chief of Pharmacy Services **Monitor:** The quality improvement monitor for inspection of drug storage areas within the Pharmacy is in place. Data is reported through the Pharmacy/Therapeutics Infection Control Committee on a quarterly basis.	03/03/08

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A 491	Continued From page 9 not indicate the documented approval of the physician regarding the administration of personal medications. 3. During a tour of the inpatient pharmacy on 1/29/08 at 9:45 am, the medication freezer, located in room ACC 63, contained three frozen dinners and one frozen apple food item. During an interview with the Pharmacist on 1/29/08 at 9:45 am, he stated that the food items should not be in the medication freezer. The freezer was located in a room that had been utilized as a janitor's closet in the past, and the signage on the door was not current. Cleaning products such as Brite Boy, Liquid Gold, and a dust pan were noted in a soiled mop sink.	A 491	Continued from page 9:	
A 500	482.25(b) CONTROL AND DISTRIBUTION OF DRUGS In order to provide patient safety, drugs and biologicals must be controlled and distributed in accordance with applicable standards of practice, consistent with Federal and State law. This STANDARD is not met as evidenced by: Based on inspection of the Malignant Hyperthermia (MH) Kit in the Surgery Department, interview of a Staff Member (Staff M), and review of the pharmacy policy and procedure regarding the Malignant Hyperthermia Kit, the hospital failed to ensure that the policy and procedure content list matched the contents	A 500	**A 500 Plan of Correction:** Drugs and biologicals will be controlled and distributed in accordance with applicable standards of practice. **Finding 1:** The list of contents for the Hyperthermia Kit was corrected. The current and correct list of contents is attached to the outside of the kit. The Pharmacy Policy and Procedure on "The Malignant Hyperthermia Kit" (Chapter III, page 23) has been revised to include a procedure on the use of the kit. Email notification was sent to Nursing Supervisors of the revised policy. **Responsible:** Assistant Pharmacy Director **Monitor:** A Licensed Pharmacist will conduct a monthly inspection of the "Hyperthermia Kit."	

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A 500	Continued From page 10 of the MH Kit and that a procedure regarding the use of the kit had been developed as required by state regulation. Findings: 1. Malignant Hyperthermia (MH) is a rare but potentially fatal side effect of the use of certain medications used in the practice of anesthesiology. The Malignant Hyperthermia Association of the United States (MHAUS) is a nationally recognized organization that establishes standards of care for the treatment of MH. On 2/11/08 at 2:05 pm an inspection of the MH Kit in the Surgery Department with Staff M revealed that it contained the drugs specified by MHAUS. Review of the policy and procedure entitled The Malignant Hyperthermia Kit revealed the content list in the policy and procedure documented the MH Kit would contain ten 100 milliliter vials of sterile water for injection while inspection of the kit revealed it contained twenty-two such vials (which was in compliance with MHAUS guidelines). The content list in the policy and procedure did not list that three 1000 ml intravenous (IV) bags of 0.9% sodium chloride was stored in the refrigerator. Inspection of the refrigerator revealed that it did contain three 1000 ml IV bags of 0.9% sodium chloride (which was in compliance with MHAUS guidelines) and these bags were listed on the content list that was posted on the outside of the MH Kit (it documented the IV bags were stored in the refrigerator). California Code of Regulations, Title 22, Section 70263(f)(1) stipulates that a written policy and procedure establishing the	A 500	**Continued from page 10:** Pharmacy policy and procedures will be reviewed annually. **Finding 2:** A Surgical Service Policy for nursing was developed on use of the Malignant Hyperthermia kit. The policy will be presented to the Pharmacy/Therapeutics Infection Control Committee for review and approval. Surgical Nurses and Supervising Registered Nurses will be in-serviced to the new policy. **Responsible:** Supervising Registered Nurse II **Monitor:** The policy will be reviewed annually by the Pharmacy/Therapeutics Infection Control Committee.	03/03/08 03/28/08

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A 500	Continued From page 11 contents of an emergency medication supply shall be developed. It is expected that the contents meet standards of practice and that the policy and procedure content list is current and accurately reflects the content of the emergency medication supply. 2. Review of the policy and procedure entitled The Malignant Hyperthermia Kit revealed it did not provide for a procedure for use of the MH Kit. When asked if there was such a procedure Staff M said he would check into it. The hospital subsequently did not produce a procedure for the use of the MH Kit that had been approved by the Pharmacy and Therapeutics Committee as required by California Code of Regulations, Title 22, Section 70263(f)(1).	A 500	**Continued from page 11:**	
A 505	482.25(b)(3) UNUSABLE DRUGS NOT USED Outdated, mislabeled, or otherwise unusable drugs and biologicals must not be available for patient use. This STANDARD is not met as evidenced by: Based on observation and interview, the hospital failed to ensure that outdated drugs were not available for patient use in one of five medication areas inspected. Findings: During inspection of the medication storage in the Ambulatory Care Center on 1/29/08 at 10:30 am, one tube of Mydfrin 2.5% ophthalmic solution, 5 ml. had expired in 12/07. Mydfrin may be used to dilate the pupil and for treatment of eye conditions.	A 505	**A 505 Plan of Correction:** Outdated, mislabeled, and unusable drugs and biologicals will not be available for patient use. **Finding:** The outdated tube of Mydfrin was discarded. Pharmacy and Nursing personnel will inspect medication supplies on a monthly basis. An environmental rounds audit tool will be developed to ensure outdated drugs are not available for patient use. **Responsible:** Pharmacy and Nursing Administration **Monitor:** The Pharmacy and Nursing Service environmental rounds audit will be performed monthly to ensure outdated drugs are returned to the Pharmacy.	03/26/08

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A 505	Continued From page 12 During an interview with the pharmacy staff on 1/29/08 at 10:30 a.m., staff acknowledged that the medication had expired and should have been discarded.	A 505	**Continued from page 12:**	
A 714	482.41(b)(7) FIRE CONTROL PLANS The hospital must have written fire control plans that contain provisions for prompt reporting of fires; extinguishing fires; protection of patients, personnel and guests; evacuation; and cooperation with fire fighting authorities. This STANDARD is not met as evidenced by: Based on interview and review of the fire drill critique forms and administrative policy VH-08-1500, the facility failed to assure their policies matched the actual practice and failed to ensure problems with fire drills were followed up. Findings: On 01/30/08 a review of Fire Drill Critique Forms revealed the following problems identified by staff: On 11/07/07 during the fire drill, the Emergency Notification System and alarms were not audible in Central Supply, ACC , 1 South and 1 North. In Radiology the automatic fire doors did not close and latch. On 1 North the critique form asked for an inservice regarding "Who the Incident Commander was." There was no written evidence of follow-up. Review of the Administrative Manual , Fire Prevention Program, Fire Drills and Alarms revealed that security staff shall initiate and	A 714	**A 714 Plan of Correction:** The hospital's fire control plan will contain provisions for prompt reporting of fires, extinguishing fires, protection of patients, personnel and guests and evacuation in coordination with fire fighting authorities. The "Fire Drill Critique" of the 11/07/07 fire drill was documented incorrectly. The inaudible alarms referenced were not meant to sound in those areas on this particular drill. The automatic fire doors in Radiology will be repaired by Plant Operations. **Responsible:** Chief of Plant Operations or designee Staff on 1North will receive training on the incident command structure. **Responsible**: Health and Safety Officer **Finding:** The VHC-Y Administrative Policy VH 08-1500 and the "Fire Drill Critique" form are being revised. Upon approval, the policy will explain the fire alarm systems utilized in the Holderman Hospital and areas of their respective coverage. The newly-revised policy statement and the form which supports it will provide for objective reports of fire drills.	03/26/08 03/26/08

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A 714	Continued From page 13 critique quarterly fire drills and forward them to Health and Safety Officer. The fire drill critique forms indicate a plan of correction would be identified for all problems. This was not evident on the critique form when the above problems were identified. In an interview with the Health and Safety Officer on 01/30/08 at 10:30 am, he said the alarms may not have been heard because it was not an actual drill and /or that there are different alarm systems within the hospital building. The facility policies do not reflect that there are different alarm systems located within the hospital building nor did they indicate the difference between an actual or silent drill. The Health and Safety Officer confirmed a plan of correction should have been evident when problems were identified on the Critique Forms.	A 714	**Continued from page 13:** In-Service training will be provided to members of the Security Service regarding proper evaluation of fire drills and accurate, objective data entry on the newly revised form. The revised "Fire Drill Critique" form will provide useful information for review and avoid confusion stemming from inappropriate data classification or labels. **Responsible**: Health/Safety Officer and Chief of Security Service **Monitor**: The Health and Safety Officer will review the "Fire Drill Critique" forms for completion and accuracy. Any issues or concerns will be followed up by the Health and Safety Officer.	03/26/08
A 724	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: Based on observation and staff interview, the hospital failed to ensure that a smoke detector was functioning properly. The hospital failure to maintain necessary equipment created the potential for prompt fire control, thus endangering	A 724	**A 724 Plan of Correction**: Facilities, supplies, and equipment will be maintained to ensure safety and quality. The inadvertent failure to remove tape from a smoke detector during the painting task was corrected immediately. VHC-Y staff assigned to painting tasks in the Plant Operations Service will be reminded to restore any equipment disabled in the process of their painting task. **Responsible**: Chief of Plant Operations or designee. **Monitor**: The Supervisor of Painting Personnel will inspect projects upon completion.	03/26/08

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A 724	Continued From page 14 patients, personnel, and guests. Findings: During the initial tour on 1/28/08 at 10:15 am, a shower room, located next to the nursing station was inspected. Observation revealed an overhead smoke detector which had been sealed with heavy blue tape. The encased smoke detector was pointed out to the licensed staff nurse that accompanied the tour. The licensed staff nurse stated that the shower was not accessible to patients and the "other" shower room was utilized for patient showers. Inquiry was made as to why the floor was wet. The licensed staff nurse opened the "other" shower room which indicated the shower room was used for storage of wheelchairs, commodes, and patient equipment. The licensed staff nurse confirmed that the first shower room observed was in fact used by patients for their showers and stated that she was unaware the fire extinguisher had been taped. The licensed staff nurse questioned a housekeeping staff member as to why the fire extinguisher had been taped. Housekeeping staff stated that she thought the fire extinguisher had been taped because the steam created by the shower spray could set off the fire alarm. On 1/29/08 at 9:00 am, administrative staff confirmed that the smoke detector in the shower room had been sealed with heavy blue tape by the maintenance department during painting, due to "paint fumes" setting off the fire sprinklers.	A 724	Continued from page 14:	
A1132	482.56(b) WRITTEN PLAN OF REHABILITATION TREATMENT Services must be furnished in accordance with a written plan of treatment. Services must be given	A1132	A 1132 Plan of Correction: The facility will ensure services are furnished in accordance with written plans of treatment.	

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A1132	Continued From page 15 in accordance with orders of practitioners who are authorized by the medical staff to order the services, and the orders must be incorporated in the patient's record. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to furnish therapy Occupational Therapy / Physical Therapy (OT/PT) services in accordance with physicians orders. This was evident in five of 20 sampled records. (1, 2, 9, 11, and 15) Findings: Record reviews on 1/28/08 and 1/29/08 identified that OT/PT evaluations were not completed in accordance with physician orders. 1. Patient 1 had a physician order dated 1/24/08 for "PT to evaluate and ambulate this am." However, on 1/25/08 only a PT screen was completed on Patient 1 and not an evaluation as ordered. 2. Patient 2's physician wrote an order on 1/24/08 for an "OT/PT eval." There was no documented evidence that an OT/PT eval was completed. Interview with the Physical Therapist on 1/29/08 at 11:30 am revealed she did not do the evaluation because she decided "a screen was warranted and not an evaluation." 3. Patient 9 had a physician's order for "OT/PT eval and tx (treatment)" dated 1/8/08. On 1/10/08,	A1132	**Continued from page 15:** **Findings 1 through 6:** The "Patient Documentation" policy has been revised to reflect that OT/PT services will be furnished in accordance with physician orders and written plans of treatment. Staff will be in-serviced that they must follow the physician's order for OT/PT services or contact the physician to clarify the orders. The Chief Medical Officer sent a memorandum to all Physicians February 15, 2008 recommending they initially order a screen for PT/OT services if warranted. **Responsible**: Chief of Rehabilitation Services or designee **Monitor**: A quality improvement monitor will be developed to ensure that all referrals for OT/PT services on 1South are responded to as written. The data will be reviewed through the Clinical Services Quality Improvement Committee.	03/26/08

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A1132	Continued From page 16 it was documented that an OT Screen and a PT Screen were completed but no OT or PT evaluations were completed. 4. Patient 11 had physician orders for "PT eval (evaluation) gait/balance s/p (status post) fall" dated 12/7/07. On 12/7/07, the PT for the GACH unit completed a "PT Screen for mobility" and a PT evaluation was never completed. 5. Patient 15 had physician's orders for "OT/PT eval" dated 7/20/07. There were no documentation that OT and PT evaluations were completed. 6. On 1/29/08 at 11:30 am, the policy and procedures for therapy evaluations and time frames to administer the evaluations were requested. At 2:30 pm, a one page Policy and Procedure (P&P) "Patient Documentation" revealed item 4 stated "Assigned therapist determines whether a screen or an evaluation is appropriate following a review of the medical chart," however, State law requires that OT/PT services must be furnished in accordance with physician's orders and in accordance with a written plan of treatment. A OT/PT evaulation is a formal interpretation of patient status that will determine whether or not physical or occupational therapy is indicated; establish diagnoses; prognosis; and identify and document the planned interventions to achieve goals. A screen is only a preliminary process of gathering and integrating information to determine the need for further examination or intervention. 7. Further investigation revealed there was no policy and procedure (P&P) on the appropriate time frame for an evaluation to be completed. The	A1132	**Continued from page 16:** **Finding 7**: The Triage Policy has been revised to establish a system to prioritize the emergent needs of the patient referred for therapy services. **Responsible**: Chief of Rehabilitation Services or designee **Monitor**: A quality improvement monitor will be developed to ensure that all referrals for OT/PT services on 1South are responded to as written. The data will be reviewed through the Clinical Services Quality Improvement Committee.	03/26/08

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A1132	Continued From page 17 Director of PT acknowledged and stated that the P&P titled "Patient Documentation" was "just updated today to make it more accurate." The Director of PT stated that the Master P&P manual was locked up in the Rehab Director's office and besides the Rehab Director, only a security staff can open that office to get the manual. However, he stated that the PT portion of the rehab manual was available in the rehab room. The Director of OT stated that the OT portion of the rehab manual was also available in the rehab room. However, they both stated that the manuals in the rehab room may not contain the most recent policies and procedures information.	A1132		